

## Outpatient Prospective Payment System (OPPS)

### Frequently Asked Questions

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1. Will the entire OPPS system be utilized, or just APC's?

**MDCH will implement an OPPS similar to Medicare OPPS.**

2. Will Michigan Medicaid be using the same Wage Index's to modify the labor portion (60%) of the APC weight, as CMS?

**Wage Indices will not be utilized. This is consistent with current MDCH outpatient hospital policy as hospitals are currently reimbursed from the Medicaid fee screen without regard to wage index.**

3. Will Michigan be using the same APC weights as CMS? **Yes**

4. Please clarify the "state wide reduction factor". Is this referring to the true CMS definition of a conversion factor as it applies to APC's (currently, the 2005 national CF is 56.983), or is it describing something that would work more like a wage index (e.g., "1.00" would mean "100%", ".985" would mean "98.5%", etc)?

**MDCH intends to use 100% of CMS's rates for all OPPS services and apply a statewide reduction factor, not a hospital-specific factor. The factor will represent estimated statewide budget neutrality. Under the proposed OPPS, it is MDCH's intent to pay 58% of the Medicare approved amount. To further clarify, if Medicare's approved amount for a particular line item (whether APC item or a fee schedule item) is \$100, MDCH will multiply the full Medicare approved amount (\$100) by the reduction factor (58%) which would result in a \$58 payment for that line.**

5. Will the Medicare APC outlier methodology be used for Michigan's APCs? If so, will the methodology be the same or will some component (e.g., threshold) be different?

**Michigan Medicaid does not currently have any outlier policy for outpatient services. We are proposing to implement Medicare's current outlier policy. It will use Medicaid Cost to Charge Ratios and will be calculated prior to a reduction factor being applied.**

6. Will Michigan's updates be consistent with current CMS (i.e., when CMS makes an update, will the same apply to MI)?

**Open Issue - To Be Determined**

7. For OPPS items that are not paid from APC (e.g, clinical lab), will CMS Clinical Lab rates apply, or will some Michigan Medicaid-specific rates take precedence.

**Michigan Medicaid specific rates will apply for these services, however, most will be based on CMS rates with a Michigan Medicaid reduction factor applied. The factor will represent estimated statewide budget neutrality.**

8. Are there any exceptions to CMS edits (e.g., CCI/OCE, inpatient only)?

**CCI and Medicare's Inpatient Only editing will be used. We are currently reviewing the OCE application and edits.**

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9. I understand that this system will make use of Medicaid provider #'s as opposed to CMS' use of Medicare ID#'s. Do you have a crossmap file (i.e., link between Medicaid ID# and Medicare ID#)?

**Please contact your contract manager to receive a copy of this file.**

10. Under current Medicare reporting the ER level is reported on the claim form. Injections, infusions, surgical repairs, x-rays and etc. are all reported separately on the claim. If my understanding is correct, under Medicaid APC the same reporting methodology will apply.

**Your statement is correct—under Michigan Medicaid's proposed OPPS/APCs we intend to follow Medicare's then current guidelines and coding/billing requirements for E&M services as closely as possible.**

11. Under its OPPS, does Michigan Medicaid intend to reimburse critical access hospitals and children's hospitals exactly like any other Michigan hospital? Children's hospitals have a "hold harmless" provision under Medicare. My understanding is that this provision will not apply under Michigan Medicaid OPPS.

**That is correct. Under our proposed OPPS, all Michigan hospitals will be reimbursed exactly the same, including Children's and CAH, no exceptions. The hold harmless provision would also not apply.**

12. Michigan Medicaid has indicated that each hospital's Medicaid outpatient cost to charge ratio will be used. Am I correct in assuming this is not the same CCR as the hospital would have for Medicare (i.e., the one published on CMS' website)? Also, is CCR only to be used in the outlier calculation? Otherwise, what is the need for CCR?

**Michigan Medicaid will be using it's own OPH cost to charge ratios. These can be found at the following link on the Medicaid/MDCH website  
[http://www.michigan.gov/documents/HospitalPricesInternet\\_Update\\_110504\\_109155\\_7.XLS](http://www.michigan.gov/documents/HospitalPricesInternet_Update_110504_109155_7.XLS) (the last tab in this Excel document has the OPH CCR).**

13. Is it correct to interpret the Michigan Medicaid term "Reduction Factor" as follows: The National APC rate (e.g., as published in Addendum A and Addendum B of [http://www.cms.hhs.gov/providers/hopps/205\\_AddA\\_B\\_Updates.asp](http://www.cms.hhs.gov/providers/hopps/205_AddA_B_Updates.asp)) \* 55% = Michigan Medicaid's APC rate"? Specifically, I'm trying to verify that you are not trying to say the 55% only applies to the *labor* portion (60%) of the APC rate, or something along those lines.

**Your statement is correct. The reduction factor will not be applied to just the labor portion. The proposed calculation under Michigan Medicaid OPPS is: Medicare's APC payment or Fee Screen Rate \* Reduction Factor (currently proposed at 58%) = Michigan Medicaid's OPPS rate. Please note that the same reduction factor will also apply to those claim lines that are paid from a fee schedule as well. In essence, the reduction factor will be applied to each individual claim line after Medicare's APC rate or Fee Schedule Pricing has been applied.**

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14. Will the OPPS project include reimbursement for DME, P&O, and Infusion Services, or more specifically, Provider Types 85, 87, and 50.

**The OPPS project is targeted for Provider Type 40 providers only. Certain limited DME/P&O and infusion services are covered under Medicare's OPPS and we are currently reviewing these services to determine Michigan Medicaid's policy under the proposed OPPS. Further clarification will be provided in the draft policy bulletin targeted for release for public comment sometime in February.**

15. Will this project affect Provider Type 10 billing professional claims on CMS 1500? Will it affect Home Care Services (Provider Type 15)?

**This project will only affect Provider Type 40 - outpatient hospitals, hospital-owned ambulance services, freestanding dialysis centers, comprehensive outpatient rehabilitation facilities, and rehab agencies.**

16. Would you consider the possibility of requiring hospitals to bill OPPS claims with Bill Types accepted under Medicare's version of OPPS? For example, a Critical Access Hospital would be required to bill with the "131" as opposed to "851".

**MDCH will require only valid Outpatient Hospital Type of Bills to be billed under the proposed OPPS. This includes 13x, 14x, 34x, 72x, 74x, 75x, or 85x Type of Bills. Critical Access Hospitals should bill using Type of Bill 13x for their Fee For Service only claims and may bill with Type of Bill 85x on their Medicare dual eligible claims. In these cases where the provider bills with an 8tx, we will have an internal systems crosswalk to change the TOB to 13x before sending the claim onto the APC software.**

17. For the MDCH specific reduction factor, is the factor going to be Date of Service specific or Date of Payment specific?? I.e., will MDCH make the reduction factor change retroactive or on a go forward basis, and will the factor be DOS specific or by Date of Payment??

**MDCH plans to implement the reduction factor on a Date of Service specific basis. Therefore, if the reduction factor is 58% initially on 10/1/06 and, based on historical OPPS claims data MDCH determines the factor should be 62% on 4/1/07, the 58% will remain in place for any DOS up until 3/31/2007 and the new reduction factor of 62% will be applicable for any DOS on/after 4/1/07 – regardless of when the claim was received/paid. This will eliminate any discrepancy in payments for same dates of service and eliminate the need for providers or MDCH to adjust previously processed claims.**